03800

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Orman

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant give residence of mother)

State: Md County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Orman (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Samuel Abramson

3. (b) Social Security Number:

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Eva Abramson

Deceased 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July, 23, - ???

8. AGE: Years: 71 Months: Days: If less than one day hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Hobudasher

FATHER

12. Name: David Lewis Abramson

13. Birthplace: Lithuania

MOTHER

14. Maiden name: Neivedel.

15. Birthplace: Lithuania

16. Informant: Meyer Abramson

Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 14, 1940 (month) (day) (year)

Cemetery or crematory: East View Cem,

Location: Cumberland

18. Funeral director: Jacob Hofer

Address: Cumberland, Md

19. April 14 1940 (Date rec'd by registrar) Mrs A. R. Walker Registrar

Dr McClain

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1940, at 2:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1940, to April 13 1940, and that I last saw him alive on April 12 1940.

Immediate cause of death: Cerebral Hemorrhage — Sudden Death — DURATION: Sudden

Due to: Arterio Sclerosis ??

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. D. McLane Jr. M.D. M. D. or other

Address: Frostburg Md Date signed: Apr 14 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03801

(948)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 310. Harrison st

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 37 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 310. Harrison st

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Anna Morgan Adams

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband ~~or wife~~ Mahlon Adams

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1865

8. AGE: Years 74 Months 7 Days 27 If less than one day hrs. min.

9. Birthplace Shephardstown W Va (Town, county, and state)

10. Usual occupation House duty

11. Industry or business Own House

FATHER 12. Name Hector Bell

13. Birthplace Shepardstown W Va

MOTHER 14. Maiden name Katherine Beaver

15. Birthplace Bardane W Va

16. Informant Mrs Albert Wagner

Address 110 Allamont Ten City

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29/40 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md

18. Funeral director William H. Kight

Address Cumberland Md

19. April 29 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to April 25, 1940, and that I last saw h alive on 19 .

Immediate cause of death Angina Pectoris (sudden).

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. C. Zimmerman M. D. or other

Address 105 S. Centre St. Cumberland Md. Date signed 4/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(94a)

03802

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 315 Offutt St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 15 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 315 Offutt St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Anderson

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kenneth E. Anderson

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Mar 7 1909

8. AGE: Years 31 | Months 1 | Days 17 | If less than one day ____ hrs. ____ min.

9. Birthplace: Dundee N. Y.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James J Bissick.
13. Birthplace: N. Y.

MOTHER
14. Maiden name: Ann Bullock.
15. Birthplace: N. Y.

16. Informant: Mrs James J Bissick.

Address: RFD #3 Bedford Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 27 40 (month) (day) (year)

Cemetery or crematory: Fellowship Cem.

Location: Cumberland Valley Pa.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. 4/27 1940 (Date rec'd by registrar) J.P. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24th 1940, at 11.40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death: Coronary Thrombosis

Due to

Due to

Other conditions: Grippe

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: none

DURATION: 2 days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Lenne H. Cosson, M.D. M. D. or other

Address: Cumberland, Md. Date signed 4/25/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

03803

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Asylum-Sylvan Retreat

Stay in hospital or inst. (yrs., or mos., or days) 9 months

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 310 Furnace St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles A Baker.

3. (b) Social Security Number 220-10-4272

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Wideowed

B (b) Name of husband or wife Edna C Robinson

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 28 1865

8. AGE: Years 74 Months 6 Days 18 If less than one day ____ hrs. ____ min.

9. Birthplace Martinsburg, Wisc.
(Town, county, and state)

10. Usual occupation Milk distributor

11. Industry or business Queen City Dairy Co.

FATHER
12. Name John D Baker
13. Birthplace West Va

MOTHER
14. Maiden name Laura
15. Birthplace

16. Informant Jesse L Baker
Address Cumberland Md.

17. Burial Date thereof April 18. 40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmont

Location Cumberland Md

18. Funeral director Louis Stein Inc.
Address Cumberland. Md

19. April 17, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/40 19 ____, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/14/40 19 ____ to 4/16/40 19 ____, and that I last saw h ___ alive on 4/16/40 19 ____.

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE Richard J. Williams M.D.
M. D. or other

Address 34 Va. Ave. Cumberland Md. Date signed 4/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Vs A15

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

03804

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 32 DAYS

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State WEST VIRGINIA County ALLEGANY

City or town RIDGELEY Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. BLOCKER STREET (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME MRS. JESSIE BARNCORD

3. (b) Social Security Number None

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife CHARLES BARNCORD

6(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) APRIL 7 1903

8. AGE: Years 37 Months — Days 17 If less than one day ___ hrs. ___ min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name JOHN RHINEHART

13. Birthplace MARYLAND

MOTHER 14. Maiden name FARRY MELLOTT

15. Birthplace MARYLAND

16. Informant Chas V Barncord

Address Ridgley W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 27, '40 (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. 4/27 1940 (Date rec'd by registrar) J.S. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 24, 1940 19 9:38 P.M, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 23 1940 to Apr 24 1940, and that I last saw her alive on April 24 1940.

Immediate cause of death Lymphatic Leukemia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Douglas Reynolds M.D. M. D. or other

Address City Date signed April 25/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

03805

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) STILLBORN FETUS

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ROBERTS PLACE, CUMBERLAND, MD. County ALLEGANY COUNTY

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

BABY BOY BERRY (STILLBORN FETUS)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	NEWBORN

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 14, 1940

8. AGE: Years	Months	Days	If less than one day
NEWBORN			hrs. min.

9. Birthplace MARYLAND (MEMORIAL HOSPITAL)
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name JOHN M. BERRY
13. Birthplace MARYLAND

MOTHER
14. Maiden name HELEN ROBERTS
15. Birthplace MARYLAND

16. Informant Memorial Hosp.
Address Cumberland, Md.

17. Cremation. Date thereof April 14, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Memorial Hosp.
Location Cumberland, Md.

18. Funeral director Sapne
Address

19 April 16 19 40 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 14 19 40, at 3:20 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1940 to April 14 1940, and that I last saw h~~e~~ ~~alive~~ dead on April 14/40 19

Immediate cause of death	DURATION
Abortion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dwight Reynolds M.D.
M. D. or other

Address City Date signed April 25/40

RECEIVED
MAY 9 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

03806

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 222 Paca St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 222 Paca St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Miss Elizabeth Bigler

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

B (b) Name of husband or wife: Single

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept 28 - 1863

8. AGE: Years 76 | Months 6 | Days 8 | If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Joseph Bigler
13. Birthplace: Germany

MOTHER
14. Maiden name: Sophina Holzkimer
15. Birthplace: Germany

16. Informant: Mrs H. R. Willison

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 9-40 (month) (day) (year)

Cemetery or crematory: St Peter & Paul's

Location: Cumberland Md

18. Funeral director: V. L. Lemperer

Address: Cumberland, Md.

19. April 8 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 - 1940, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/29/40 19__ to 4/6/40 19__, and that I last saw her alive on 4/6/40 19__.

Immediate cause of death: Hypostatic pneumonia

Due to: Bronchial pneumonia - Cut R. Duration: 48 hours.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland Md Date signed 4/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2)

CERTIFICATE OF DEATH

03807

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) STILLBORN

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MARYLAND Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 24 Ridgeway Terrace (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME BABY GIRL BINGHAM, (STILLBORN)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 9, 1940

8. AGE: Years | Months | Days | If less than one day STILLBORN hrs. min.

9. Birthplace MARYLAND, CUMBERLAND ALLEGANY (Town, county, and state)

10. Usual occupation NEWBORN

11. Industry or business

FATHER 12. Name GEORGE BINGHAM

FATHER 13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden name GOLDIE ~~Bohrer~~

MOTHER 15. Birthplace WEST VIRGINIA

16. Informant Memorial Hosp.

Address Cumberland, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof April 9, 1940 (month), (day) (year)

Cemetery or crematory Memorial Hosp.

Location Cumberland, Md

18. Funeral director Same

Address

19. April 11, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 9, 1940 STILLBORN @12:09 A.M 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 .

Immediate ~~cause~~ of death Twisted Umbilical Cord Stillborn

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mary E. Bennett M. D. or other

Address Cumberland Md Date signed 4/10/40.

RECEIVED
MAY 9 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03808

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days): 15 days

Stay in this community (yrs., or mos., or days): 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Woodland, Md. Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Near Frostburg, Md. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Annie Jenkins Bittinger

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Olen Bittinger

6(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): May 31, 1898

8. AGE: Years: 41 Months: 10 Days: 11 If less than one day: hrs. min.

9. Birthplace: Borden Mine, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Home

FATHER 12. Name: John B. Jenkins

13. Birthplace: Wales

MOTHER 14. Maiden name: Delia Norris

15. Birthplace: Mt Savage, Maryland

16. Informant: Olen Bittinger

Address: Woodland, Md. Near Frostburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 14, 1940 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Moscow, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. April 13 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1940, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 29 1940, to Apr 12 1940, and that I last saw her alive on Apr 11 1940.

Immediate cause of death	DURATION
Cerebral Embolism	2 wks
Due to Acute Endocarditis	3 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: no

Of autopsy: no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. D. McLane Jr. M.D. M. D. or other

Address: Frostburg Md. Date signed: Apr 13 1940

RECEIVED
MAY 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-D)

03809

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md
(If outside city or town limits, writes RURAL NEAR and give town)

Street address, hospital, or institution: 132 Springdale St.,

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 27 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 132 Springdale St.,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Zelma L. Brant

3. (b) Social Security Number None

4. Sex F.

5. Color or race W.

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Theodore Brant

8 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) March 5 – 1900

8. AGE: Years 40 | Months — | Days 26 | If less than one day ___ hrs. ___ min.

8. Birthplace Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Walter Hudson
13. Birthplace Md

MOTHER
14. Maiden name Julia M. Shattle
15. Birthplace Md

16. Informant Theodore Brant

Address Cumberland Md

17. Burial Date thereof Apr 3 – 40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmont

Location Cumberland, Md.

18. Funeral director V. L. Lamparow

Address Cumberland, Md.

19. April 3, 1940 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April, 1940, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1938, to April 1 1940 and that I last saw h[illegible] alive on March 31 1940.

Immediate cause of death Carcinoma of Rectum

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Carcinoma of Rectum

Of autopsy

DURATION About 1938

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury no Injured at work?

23. SIGNATURE M E B Owens
M. D. or other

Address 133 Va Ave Date signed 4/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

03810 10 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Barrellsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 10 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Barrellsville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas Theodore Bridges

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10 1910

8. AGE: Years 30 | Months 3 | Days 11 | If less than one day hrs. min.

9. Birthplace Beaverton Pa.

(Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER 12. Name Jacob P Bridges

13. Birthplace Pa.

MOTHER 14. Maiden name Fannie Blusher.

15. Birthplace Md.

16. Informant Jacob P Bridges

Address Barrellsville Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Apr 23 '40 (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem

Location Cumberland Md.

18. Funeral director Louis Stein Sons.

Address Cumberland.

19. 4/23/40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st., 1940, at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ____, 19____, to ____, 19____, and that I last saw h____ alive on ____, 19____.

Immediate cause of death	Coronary Thrombosis	DURATION
Due to		
Due to		
Other conditions	Rheumatic Fever since age of 7	

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Pierce H. Borson, M.D.

M. D. or other

Address Cumberland, Maryland Date signed 4/22/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAY 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

CERTIFICATE OF DEATH

03811

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Bedford Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: BRILL, BABY BOY (Stillborn)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 16, 1940

8. AGE: Years: Stillborn | Months | Days | If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Arthur Brill
13. Birthplace: Maryland

MOTHER
14. Maiden name: Charlotte Hoffmeister
15. Birthplace: Maryland

16. Informant: Memorial Hosp.
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal): Date thereof: 4/16/40 (Month) (day) (year)
Cemetery or crematory: St. Marys Cem.
Location: Lonaconing, Md.

18. Funeral director: Wm. H. Light
Address: Cumberland, Md.

19. April 16 19 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 16 1940, at 12 03 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 16 1940, to Apr. 16 1940, and that I last saw him alive on Stillborn 19

Immediate cause of death: Intracranial birth injury — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M. D.
M. D. or other
Address: 40 N. Liberty St. Date signed: 4-16-40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03812

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: Allegany Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 2 days.
Stay in this community (yrs., or mos., or days) 75 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 513 Oldtown Rd
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Brinker

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Ann Powers
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Oct - 1864
8. AGE: Years: 75 | Months: 5 | Days: | If less than one day: ____ hrs. ____ min.
9. Birthplace: Cumberland Md (Town, county, and state)
10. Usual occupation: Contractor
11. Industry or business: Slate.
FATHER 12. Name: Casper Brinker
13. Birthplace: Germany
MOTHER 14. Maiden name: Mary Swartz.
15. Birthplace: Germany
16. Informant: John C Brinker
Address: Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 20 '40 (month) (day) (year)
Cemetery or crematory St Peter & Pauls Cem
Location Cumberland Md
18. Funeral director: Louis Stein Sons
Address: Cumberland Md.
19. April 20, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18-40 19 ____, at 6A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-16-40 19 ____, to 4-19-40 19 ____, and that I last saw h- alive on 4-17-40 19 ____

Immediate cause of death	DURATION
Cerebral Hemorrhage	
with right hemiplegia	1 wk
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Dt operations
Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE W. Alfred Va Deusen, M.D.
M. D. or other
Address Cumberland, Md. Date signed 4-19-40

RECEIVED
MAY 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03813

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Shaft

(If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 25 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Shaft Ward No.

(If outside city or town limits, write RURAL, NEAR and give town)

Street No.: Near Frostburg, Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George M. T. Buckalew

3. (b) Social Security Number: 220-10-2732

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Grace L. Wilson

6(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Aug. 2, 1869

8. AGE:

Years	Months	Days	If less than one day
70	8	3	hrs. min.

9. Birthplace: Near Moorefield, W. Va.

(Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mining

FATHER

12. Name: John M. Buckalew

13. Birthplace: Unknown

MOTHER

14. Maiden name: Eva C. Fragenbaker

15. Birthplace: Unknown

16. Informant: Russell Buckalew

Address: Centre St., Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 13, 1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: Mr. Eichhorn

Address: Lonaconing, Md

19. April 11 1940 (Date rec'd by registrar) Mrs. J. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1940, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/15/40 1940 to 4/9/40 1940, and that I last saw him alive on 4/9/40 1940.

	DURATION
Immediate cause of death: Chronic Fibroid Pulmonary Tuberculosis &	
Due to: Anthracosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: nr

Of autopsy: nr

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John Kilday, M.D. M. D. or other

Address: 56 W. Main Street, Frostburg, Md. Date signed: 4/11/40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

03814

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Barclay Avenue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 68 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Barclay Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Charles Buckholtz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Elizabeth Wilson

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1861

8. AGE:

Years	Months	Days	If less than one day
79	1	—	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: Locomotive (Mine)

FATHER
12. Name: Buckholtz
13. Birthplace: Germany

MOTHER
14. Maiden name: Upbrooks
15. Birthplace: Germany

16. Informant: Walter Buckholtz
Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24 1940 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md

18. Funeral director: W. Eichhorn
Address: Lonaconing, Md.

19. April 24 1940 (Date rec'd by registrar) Dr. E. Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1940, at 6:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1939, to April 22 1940, and that I last saw h— alive on April 1 1940.

Immediate cause of death	DURATION
Apoplexy (cerebral hemorrhage)	
Due to: arterio-sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work? —

23. SIGNATURE: Dr. E. Dorsey M. D. or other
Address: Lonaconing Date signed: April 24-1940

RECEIVED
MAY 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2) CB

03815

CERTIFICATE OF DEATH

Reg. Dist. No. 4

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(T)

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 221 Averitt Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State New York. County

City or town Brooklyn Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Myles Joseph Burns (Byrne)

3. (b) Social Security Number 060-03-0651

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Elizabeth Burns.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3 1878

8. AGE: Years 61 Months 4 Days 21 If less than one day hrs. min.

9. Birthplace Ocean, Allegany Co Md (Town, county, and state)

10. Usual occupation Foreman.

11. Industry or business Telephone Co.

FATHER 12. Name Timothy Burns.

13. Birthplace Ireland.

MOTHER 14. Maiden name Sarah Collins

15. Birthplace Ireland

16. Informant Mrs R. A. Morgan

Address Cumberland

17. Removal & burial (Burial, cremation, or removal. Which?) Date thereof Apr 26 '40 (month) (day) (year)

Cemetery or crematory

Location Rensselaer. N. Y.

18. Funeral director Louis Stein Inc

Address Cumberland.

19. April 25 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1940, at 2a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1940 to April 24 1940, and that I last saw him alive on April 24 1940.

Immediate cause of death Uremia

Chr myocarditis

Chr interstitial nephritis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

DURATION ?

?

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Lyle R. Everhart MD M. D. or other

Address 36 Queens St Date signed 4/24-40

RECEIVED
APR 26 1940
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2)

CERTIFICATE OF DEATH

03816 9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Allegany

City or town Midlothian
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Midlothian Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Chapman

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	W	Stillbirth

6 (b) Name of husband or wife Stillbirth

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 1 1940

8. AGE: Years | Months | Days | If less than one day: hrs. min.

Stillbirth

9. Birthplace Midlothian Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Lester Chapman

FATHER 13. Birthplace Midlothian Md

MOTHER 14. Maiden name Bessie Willetts

MOTHER 15. Birthplace Midlothian

16. Informant Lester Chapman

Address Midlothian

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1st 1940 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md

18. Funeral director Father Lester Chapman

Address Midlothian Md.

19. April 1st 1940 (Date rec'd by registrar) Mrs. A. P. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 1 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Stillborn to 19,

and that I last saw h alive on 19,

Immediate cause of death Death of Foetus in Utero — DURATION

Due to — DURATION

Due to — DURATION

Other conditions — DURATION

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane M.D.
M. D. or other

Address Frostburg Md Date signed Apr 1 1940

RECEIVED
APR 3 1948
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03817

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 5 Mary St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: BABY GIRL CLARK (STILLBORN)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): APRIL 9, 1940

8. AGE: Years: Stillborn | Months | Days | If less than one day: hrs. min.

9. Birthplace: MARYLAND, Cumberland
(Town, county, and atate)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: MARY ELIZ. CLARK
15. Birthplace: MARYLAND, Loraconing

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: April 9, 1940 (month) (day) (year)
Cemetery or crematory: Memorial Hosp.
Location: Cumberland, Md.

18. Funeral director: Same
Address:

19. April 11, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9, 1940, at 9:42 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__,
and that I last saw h__ alive on ____ 19__.

Immediate cause of death: Stillborn
Intrauterine Asphyxia

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Mary E. Turner M. D. or other
Address: Cumberland, Md. Date signed: 4/10/40

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MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (528)

03818

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 mo.
Stay in this community (yrs., or mos., or days): 60 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 528 Washington St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Perry Clayton

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed or divorced
Male	Colored	Single

6 (b) Name of husband or wife: —

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): about 1845

8. AGE: Years: about 94 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Easton Md.
(Town, county, and state)

10. Usual occupation: House man.

11. Industry or business: Private Home.

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown.
15. Birthplace:

16. Informant: W. Wallace McKaig
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 20 40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland Md.

18. Funeral director: Louis Stein Sons.
Address: Cumberland.

19. April 19, 1940 (Date rec'd by registrar) J. L. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1940, at 4:00 a m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1940, to April 18 1940, and that I last saw him alive on April 18 1940.

Immediate cause of death: Carcinoma of Bladder.

DURATION

Due to: ____

Due to: ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ____
Of autopsy: ____

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 172 So Centre St Date signed 4-18-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

Division of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03819

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town) Rt 4

Street address, hospital, or institution: Narrows Park

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Md County Allegany

City or town Cumberland Rt 4 Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Narrows Park (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Angus A. Combs

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Anna L. Buckley

6(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.): Dec 2 - 1879

8. AGE: Years 60 | Months 4 | Days 4 | If less than one day: ____ hrs. ____ min.

9. Birthplace: West Va. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Cabinet Worker.

FATHER

12. Name: John Combs

13. Birthplace: West Va

MOTHER

14. Maiden name: Harriet Brock

15. Birthplace: West Va

16. Informant: Mrs Anna L. Combs

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 8-40 (month) (day) (year)

Cemetery or crematory: Hillcrest Bur. Park

Location: Cumberland Md

18. Funeral director: W. L. Tennant

Address: Cumberland, Md

19. April 8 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 6 - 1940, at 12:[illegible] M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1940, to April 1940, and that I last saw him alive on April 1940

Immediate cause of death: Dilatation of heart (acute) Pulmonary edema

Due to: Chr myocarditis Hypertension

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:

20 operations: —

20 autopsy: —

DURATION: ½ yrs. 1 "

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Cyrle R. Eisenhart M.D. M. D. or other

Address 36 Greene St., Cumberland, Md. Date signed 4/8/40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

03820

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92-d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 529 Patterson Ave

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No. ✓ (If outside city or town limits, write RURAL NEAR and give town)

Street No. 529 Patterson Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Simon Creegan

3. (b) Social Security Number: none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Miller

6(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): July 28, 1901

8. AGE: Years: 38 Months: 8 Days: 20 If less than one day: hrs. min.

9. Birthplace: Midland, Maryland (Town, county, and state)

10. Usual occupation: Sheet Metal Worker

11. Industry or business

FATHER
12. Name: Patrick Creegan
13. Birthplace: Midland, Md.

MOTHER
14. Maiden name: Anne Kenny
15. Birthplace: Midland, Md.

16. Informant: Mrs. Simon Creegan

Address: 529 Patterson Ave., City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 20, 1940 (month) (day) (year)

Cemetery or crematory: St. Patricks Cem

Location: Cumberland, Md

18. Funeral director: V. L. Lempereur

Address: Cumberland, Md

19. April 20, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1940, at 4:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1940, to April 18 1940, and that I last saw him alive on April 13 1940.

Immediate cause of death: Acute Dilatation of Heart — DURATION: 1 hour

Due to: Chronic Myocarditis and Endocarditis — 1 year

Due to: Arthritic Deformans — 10 yrs

Other conditions: (Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. or other

Address: 41 Emmet Co Cumberland Date signed: April 19 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

03821

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Mines Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart Mines Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Hattie Engle

3. (b) Social Security Number None

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Vincent Engle

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 — 1869

8. AGE: Years 71 Months 7 Days 28 If less than one day hrs. min.

9. Birthplace Eckhart - alleg. - Md (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Josiah Porter

13. Birthplace Eckhart, Md.

MOTHER 14. Maiden name Mary Lewis

15. Birthplace Wales

16. Informant Vincent Engle

Address Eckhart Mines, Md.

17. Porter cemetery (Burial, cremation, or removal. Which?) Date thereof April 5-1940 (month) (day) (year)

Cemetery or crematory Porter cemetery

Location Eckhart, Maryland

18. Funeral director L. J. Durst

Address Frostburg, Maryland

19. 4 — 5 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1940, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1940, to Apr. 2 1940; and that I last saw her alive on Apr. 2, 1940.

Immediate cause of death Carcinoma left breast with metastasis

Due to to abdominal viscera

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Left breast amputated in Jan. 1940

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Diehl M.D. M. D. or other

Address Frostburg, Md. Date signed 4/4/40

RECEIVED
MAY 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

03822

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 761. Fayette st
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W Va County Hampshire
City or town Romney Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Jemima Fisher

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband ~~or wife~~ Robert S. Fisher
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Nov 16 1858

8. AGE: Years 81 | Months 5 | Days 13 | If less than one day ____ hrs. ____ min.

9. Birthplace Romney Hampshire Co. W Va (Town, county, and state)
10. Usual occupation House duty
11. Industry or business Own House

FATHER
12. Name Silas Lewis
13. Birthplace West Virginia

MOTHER
14. Maiden name Abigail Hannas
15. Birthplace West Virginia

16. Informant Mrs J. E. Ultz
Address Mt. Pleasant, W Va
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1/40 (month) (day) (year)
Cemetery or crematory Indian Mound Cem
Location Romney W Va
18. Funeral director William H. Kight
Address Cumberland Md
19. April 30 1940 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1940, at 5 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 1 1940 to April 29 1940, and that I last saw her alive on April 29 1940.

Immediate cause of death	DURATION
Diabetes Mellitus	1930
Due to	
Due to	
Other conditions Arteriosclerosis	1930

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. W. Eliason MD M. D. or other
Address 126 Union St. Cumberland Md Date signed 4/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

03823

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hosp.

Stay in hospital or inst. (yrs., or mos., or days) 1 day

Stay in this community (yrs., or mos., or days) 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Garrett

City or town Crellin Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Friend

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1940

8. AGE: Years | Months | Days 2 | If less than one day hrs. min.

9. Birthplace Crellin, Garrett Co., Md. (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER: 12. Name John R. Friend

13. Birthplace W. Va.

MOTHER: 14. Maiden name Dollie Lewis

15. Birthplace Md.

16. Informant John R. Friend, Father

Address Crellin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5, 1940 (month) (day) (year)

Cemetery or crematory Underwood Cem

Location Crellin, Md

18. Funeral director Emroy Bolden

Address Oakland, Md.

19. April 4, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1940, at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3, 1940, to April 4 1940, and that I last saw him alive on April 3, 1940.

Immediate cause of death: Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Gleason M. D. or other

Address 12 E. Union St. Date signed 4/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03824

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Allegany

City or town Mt Savage

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 23 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Mt Savage Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James Gordon.

3. (b) Social Security Number 212-12-8022

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced married.

6 (b) Name of husband or wife Molly Gordon

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 18 - 1876

8. AGE: Years 63 Months 9 Days 5 If less than one day ___ hrs. ___ min.

9. Birthplace Green Ridge Allegany Co Md.

(Town, county, and state)

10. Usual occupation Coal Miner

11. Industry or business Coal Mining

FATHER

12. Name James Gordon

13. Birthplace Green Ridge Md

MOTHER

14. Maiden name Harriet Middleton

15. Birthplace Flintstone, Md.

16. Informant David Powell

Address Mt Savage Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 26 1940 (month) (day) (year)

Cemetery or crematory Home Cemetery on the Home Place

Location Near Mt Savage Md

18. Funeral director Jacob Hafer

Address Frostburg Md.

19. Apr. 24 1940 H J Bostetter M D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1940, at 6.30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death Hemmorrhage from throat & nose

DURATION 10 minutes

Due to Don't know — was dead when I arrived.

Due to Seemed to me to be of pulmonary origin — Had not been treated or examined by a physician for several years

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H J Bostetter M D. M. D. or other

Address Mt Savage Md Date signed 4/24-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

03825

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Route #2 Clinton Road
(If rural give LOCATION) Cumberland Md

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Grayson

3. (b) Social Security Number none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Apr 14, 1940

8. AGE: Years | Months | Days: 1 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Jack Grayson
13. Birthplace: Keyser W. Va

MOTHER
14. Maiden name: Geneva Jones
15. Birthplace: Cumberland, Md.

16. Informant: Mrs J. E. Jones
Address: Clinton Road Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 16, 40 (month) (day) (year)

Cemetery or crematory St Lukes

Location: Cumberland Md

16. Funeral director: Jacob Hofer

Address: Cumberland Md

19 April 16 19 40 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 15, 1940, at 12:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 14, 1940, to Apr. 15, 1940, and that I last saw him alive on Apr. 14, 1940.

	DURATION
Immediate cause of death: Prematurity (28 wks gestation)	4-14-40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arthur T. Jones M. D.
M. D. or other

Address 40 N. Liberty St. Date signed 4-15-40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03826

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Wineow St
Stay in hospital or inst. (yrs., or mos., or days): 4 yrs
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Wineow St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Carl H. Johnson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife: unknown

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6/8/1877

8. AGE:

Years	Months	Days	If less than one day
62	10	22	hrs. min.

9. Birthplace: Sweeden
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: B J Johnson
13. Birthplace: Sweeden

MOTHER
14. Maiden name: Johannah Peterson
15. Birthplace: Sweeden

16. Informant: Mrs. Axel Anderson
Address: Wilcox Pa

17. Burial (Burial, cremation, or removal, Which?) Date thereof: May 3/40 (month) (day) (year)
Cemetery or crematory: Wilcox Cemetery
Location: Wilcox Pa

18. Funeral director: Wm H. Knight
Address: Cumberland Md

19. May 2 19 40 J. P. Franklin, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30th., 1940, about 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

	DURATION
Immediate cause of death: Accidental burning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 4-30-40
Where did injury occur? Cumberland, Allegany, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): home (abandoned boat
Means of injury: burning Injured at work? no

23. SIGNATURE: Prince H. Johnson, M. D.
M. D. or other
Address: Cumberland, Maryland. Date signed: 4/30/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

03827

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 day

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Little Orleans Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: CARL JOY

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 21, 1931

8. AGE: Years 8 Months 8 Days 9 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Oscar Joy
13. Birthplace Maryland

MOTHER
14. Maiden name Jessie Norris
15. Birthplace Pennsylvania

16. Informant OSCAR JOY

Address LITTLE ORLEANS, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1940 (month) (day) (year)

Cemetery or crematory Piney Grove Cem.

Location Baltimore Pike 20 miles East

18. Funeral director Ephriam Smith

Address R.D.#1 Artemus, Penna.

19. May 1, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. GROVE

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 30, 1940 8;25 P.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 30 1940, to Apr. 30 1940, and that I last saw him alive on Apr. 30 1940.

Immediate cause of death: Third degree burn of chest, abdomen, and arms

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 12 hrs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4/30/40

Where did injury occur? Piney Grove, Allegany Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury fire from stone Injured at work?

23. SIGNATURE D. B. Grove, M.D. M. D. or other

Address Midland Bldg Date signed 5/1/40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH 60

2411 N. Charles St., Baltimore (94a)

03828

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 23 hours

Stay in this community (yrs., or mos., or days) 23 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Oakland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. #2
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Virginia T. Knepp

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband ~~or wife~~ Henry C. Knepp

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10, 1876

8. AGE: Years 63 Months 6 Days 9 If less than one day hrs. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Rumer
13. Birthplace West Virginia

MOTHER
14. Maiden name Clara Mangold
15. Birthplace West Virginia

16. Informant Henry C. Knepp

Address Rural, Oakland, Md.

17. Redhouse Md Date thereof April 21 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery ~~or crematory~~ Redhouse Cemetery

Location on Route 219

18. Funeral director D. C. Bolden

Address Oakland Md

19. April 20, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1940, at 5:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18-40 19 , to 4-19 1940, and that I last saw her alive on 4-19-40 19

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 2 wks

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Ome, M.D.
M. D. or other

Address Cumb. Md. Date signed 4-19-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

03829

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 1 DAY

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State CRESAPTOWN, MARYLAND County

City or town Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MR. HENRY J. KNIERIEM

3. (b) Social Security Number None

4. Sex MALE

5. Color or race WHITE

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Anna Sipple Knieriem

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCTOBER 5, 1860

8. AGE: Years 79 Months 6 Days 23 If less than one day hrs. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name John Knieriem

13. Birthplace Germany

MOTHER 14. Maiden name ANNA CATHERINE BUSHMAN

15. Birthplace Germany

16. Informant Mr. Norman Knieriem

Address Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 30, 1940 (month) (day) (year)

Cemetery or crematory HillCrest Cem.

Location Cumberland, Md.

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. April 29 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 28, 1940 19 8:35 A.M, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1940, to April 28 1940 and that I last saw h 1 m alive on April 28 1940

Immediate cause of death Bronchopneumonia — DURATION 3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: —

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury — Injured at work?

23. SIGNATURE W R Hodges Jr, M.D. M. D. or other

Address Cumberland, Md Date signed 4/29/40

DR. W. R. HODGES

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (I) (T)

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

03830

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 4 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Va. County:
City or town: Lynnellton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: V

3. (a) FULL NAME: Scott Knotts

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary Ruckle Knotts
6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): June 15, 1876

8. AGE: Years	Months	Days	If less than one day
63	10	4	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Blacksmith
11. Industry or business:

FATHER
12. Name: William Knotts
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Margaret St.Clair
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22. 40 (month) (day) (year)
Cemetery or crematory: Lynnellton West Va
Location: Lynnellton, West Va
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.

19. April 20, 1940 (Date rec'd by Registrar) J.P. Franklin, M.D. Registrar

DR. TOLSON

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19th, 1940, at 1:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-15- 1940 to 4-19 1940, and that I last saw h-im alive on 4-19- 1940.

	DURATION
Immediate cause of death: Benign hypertrophy prostate	several years
Due to Patient accidentally fell out of bed, striking his head, resulting in cerebral concussion and fatal	
Due to fracture of skull C.W.S.R.	
Other conditions: Probable cerebral concussion (Include pregnancy within 3 months of death)	9-10 hours

Major findings:
Of operations: Benign prostatic hypertrophy - prostate resection 4-17-40
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident, A.M. Date of April 20, 1940.
Where did injury occur? in Hospital. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: fell out of bed. Injured at work?

23. SIGNATURE: Howard L. Tolson M.D. M. D. or other
Address: Cumberland, Md. Date signed 4-19-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-C)

CERTIFICATE OF DEATH

03831

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cresaptown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Robert Frederick Lafferty

3. (b) Social Security Number 217-10-4105

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Edna Winters

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 11, 1905

8. AGE:

Years	Months	Days	If less than one day
34	4	25	hrs. min.

9. Birthplace: Allegany Grove, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation: Filtration Department

11. Industry or business: Celanese Corporation

FATHER 12. Name: Jacob Lafferty

13. Birthplace: Maryland

MOTHER 14. Maiden name: Clara Finley

15. Birthplace: Maryland

16. Informant: Earl Lafferty

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8 1940 (month) (day) (year)

Cemetery or crematory: M. E. Cemetery

Location: Eckhart, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland Maryland

19 April 8 1940 (Date rec'd by registrar) J. P. Franklin, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5th., 1940, at about 2.15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__

Immediate cause of death: Poisoning. — DURATION

Drinking lysol

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: 4/5/40

Where did injury occur? Cresaptown, Allegany, Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: drinking about 2 ozs. lysol. Injured at work? no

23. SIGNATURE: Pierce H. Dorsey, M.D.
M. D. or other

Address: Cumberland, Maryland. Date signed: 4/6/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

03832

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 617 Frontenac Ave.

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 617 Frontenac Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah M. Lightner

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife David Lightner

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec 24 1853

8. AGE:

Years	Months	Days	If less than one day
86	3	26	____ hrs. ____ min.

9. Birthplace Va.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home.

FATHER 12. Name Asa Walthrup

13. Birthplace Virginia

MOTHER 14. Maiden name Ann Murray

15. Birthplace Virginia

16. Informant Elmer Lightner

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 23 40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

19. April 23 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1940 21. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1940, to April 20 1940, and that I last saw h[illegible] alive on April 19 1940

Immediate cause of death Pneumonia.

	DURATION
Due to	7 ds.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) No

Means of injury Injured at work?

23. SIGNATURE M E Bowers M. D. or other

Address 133 Va Ave Date signed 4/25/40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

03833

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 164 Bedford St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 164 Bedford St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ollie Lillis

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James H. Lillis

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): About 1865

8. AGE: Years: 75 Months: Days: If less than one day: hrs. min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: Andrew J. Ryland

13. Birthplace: Md

MOTHER 14. Maiden name: Mary Morrison

15. Birthplace: Md

16. Informant: Joseph Ryland

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5. 40 (month) (day) (year)

Cemetery or crematory: St. Patrick

Location: Cumberland Md

18. Funeral director: Louis Stein Son

Address: Cumberland, Md

19. April 4, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2nd., 1940, about 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____, 19__, to ____, 19__, and that I last saw h__ alive on ____, 19__.

Immediate cause of death: Fractured skull — Killed instantly — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 4/2/40

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: Fall on stairs Injured at work? no

23. SIGNATURE: Bruce H. Barrow, M.D. M. D. or other

Address: Cumberland, Maryland. Date signed 4/3/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAY 17 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(942)

038349

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany.

City or town Zilhman Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 38 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Zilhman Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Chester Adam Lohr

3. (b) Social Security Number 212-10-6314

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth Geary

6(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Nov 9, 1886

8. AGE: Years	Months	Days	If less than one day
53	5	3	hrs. min.

9. Birthplace Bittinger, Garrett Co. Md.
(Town, county, and state)

10. Usual occupation Kiln Fireman.

11. Industry or business Brick Yard

FATHER 12. Name Jacob Lohr.

FATHER 13. Birthplace Unknown.

MOTHER 14. Maiden name Kathryn Raley.

MOTHER 15. Birthplace Unknown

16. Informant Mrs. Chas Geary
Address Zilhman, Md.

17. Burial Date thereof Apl 14, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Jacob Hofer.
Address Frostburg, Md.

19. April 13 1940 Mrs A. L. R. Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1940, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1940, to April 12 1940, and that I last saw him alive on April 11 1940.

Immediate cause of death Coronary occlusion — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE A M Earle Jr MD
M. D. or other

Address Frostburg Md. Date signed 4-13-40

Dr Earle.

RECEIVED
MAY 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

CERTIFICATE OF DEATH

03835

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days) 30 days.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 317 Central Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry B. Wales

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Anna Powell
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1873

8. AGE: Years	Months	Days	If less than one day
67	1	20	hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)
10. Usual occupation Laborer.
11. Industry or business
FATHER 12. Name Thomas Wales
13. Birthplace Md.
MOTHER 14. Maiden name Catherine Carey
15. Birthplace Md
16. Informant Mrs Pearl Peck.
Address Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 8 '40 (month) (day) (year)
Cemetery or crematory Summer Cem.
Location Cumberland
18. Funeral director Lonis Stein Inc
Address Cumberland
19. April 8 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1940, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31, 1940, to April 4, 1940, and that I last saw him alive on April 4, 1940.

Immediate cause of death — DURATION

Carcinoma of pharaynx — 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. M. Mackle M. D. or other
Address Cumberland, Md. Date signed 4-7-40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

CERTIFICATE OF DEATH

03836

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 74 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 432 Pine Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret L. Wales.

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Lawrence B. Wales.
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1914

8. AGE:

Years	Months	Days	If less than one day
74	11	24	hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Philip Hill
13. Birthplace W. Va.
MOTHER 14. Maiden name Blanche Edwards
15. Birthplace Md.
16. Informant Mrs Ernest C. Williams
Address 647 S. Mechanic St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1 40 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland, Md.
18. Funeral director Louis Stein Inc.
Address Cumberland Md.
19 May 1 (Date rec'd by registrar) 19 40 J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1940, at 6:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1940, to April 28 1940
and that I last saw h alive on April 28 1940.

Immediate cause of death	DURATION
Pelvic cellulitis and Multiple abscesses	2 Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Operations Pelvic cellulitis & multiple abscesses & abdominis
Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James J. Doherty M.D.
M. D. or other
Address Cumberland Md Date signed 4-30-40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (44a)

CERTIFICATE OF DEATH

03837

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 518 Washington St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 518 Washington St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lalitte Nash Mc Kaig

3. (b) Social Security Number 219-03-8233

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife W. Wallace Mc Kaig

6(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) March 1, 1891

8. AGE:

Years	Months	Days	If less than one day
49	1	13	hrs. min.

9. Birthplace St. Louis, Mo.

(Town, county, and state)

10. Usual occupation Housewife ~~Vice President~~

11. Industry or business Cumberland Steel Corp.

FATHER 12. Name Charles H. Nash

13. Birthplace Canada

MOTHER 14. Maiden name Isabelle Tracy

15. Birthplace St. Louis, Mo.

16. Informant W. Wallace Mc Kaig

Address Cumberland

17. Remains (Burial, cremation, or removal. Which?) Date thereof Apr. 16, '40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland

19 April 15, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1940, at 1:00 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1940, to April 14 1940, and that I last saw her alive on April 13 1940.

	DURATION
Immediate cause of death	
Coronary Thrombosis	
Due to	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	
Major findings:	
Of operations	
Of autopsy	

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. B. Mearkle M. D. M. D. or other

Address 174 So Centre St Date signed 4-15-40

RECEIVED
MAY 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

03838

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH:

County: Allegany

City or town: Cresaptown (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Mc Mullen Highway

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 83 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Allegany County: Allegany

City or town: Cresaptown Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Mc Mullen Highway (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: George James McKenzie

3. (b) Social Security Number: None.

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Hershberger

6(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Feb 22, 1857

8. AGE: Years: 83 Months: 1 Days: 23 If less than one day: hrs. min.

9. Birthplace: Rawlings, Allegany, Md. (Town, county, and state)

10. Usual occupation: Trackman

11. Industry or business: Railroad.

FATHER

12. Name: Daniel McKenzie

13. Birthplace: Rawlings, Md.

MOTHER

14. Maiden name: Sarah Spencer

15. Birthplace: Rawlings, Md.

16. Informant: Leo McKenzie

Address: Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 17 (month) 1940 (day) (year)

Cemetery or crematory: St. Ambrose

Location: Cresaptown Md.

18. Funeral director: Jacob Hafer

Address: Cumberland, Md.

19. 4/17 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1 1940, to Apr 15 1940, and that I last saw him alive on Apr 15 1940.

Immediate cause of death: Menin Coma — DURATION: 7 Days

Due to: Organic Heart Disease — 5 yrs

Due to: Nephritis Chronic — 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Thos A. Kane M. D. or other

Address: Cumberland Md. Date signed: 4/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

T

RECEIVED
MAY 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

03839

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 10 East St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 10 East St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn Mickey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
♀	White	

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 16, 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Cumberland, Md. Allegany Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name William F. Mickey

13. Birthplace Beryl, W. Va.

MOTHER 14. Maiden name Hattie Louise Parsons

15. Birthplace Jelota, Georgia

16. Informant Mrs Hattie L. Parsons Mickey

Address Cumberland, Md.

17. Cremation 4/19/40
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory 10 East St. Cumberland

Location Own Home,

18. Funeral director Mr. Wm. Mickey

Address 10 East St. Cumberland

19. April 20, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1940, at 11 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr 16 1940, to Apr 16 1940, and that I last saw h alive on 19

Immediate cause of death	DURATION
Stillbirth	2 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Trowskis M.D. M. D. or other

Address Cumberland, Md. Date signed 4/19/40

RECEIVED
MAY 1 1908
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-00)

CERTIFICATE OF DEATH

03840

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 808 Bedford St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 808 Bedford St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Florence Miller

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Wm. Miller

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept 24 1868

8. AGE: Years	Months	Days	If less than one day
71	5	18	hrs. min.

9. Birthplace: Cumberland, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER
12. Name: Thomas Runkles.
13. Birthplace: Md.

MOTHER
14. Maiden name: Caroline Bruey
15. Birthplace: Md.

16. Informant: Henry Miller
Address: Cumberland.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Apr. 14 '40

Cemetery or crematory: St Lukes Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. (Date rec'd by registrar) April 15, 1940 J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-12-1940, at 2 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1-1940 to 4-12-1940 and that I last saw her alive on 4-7-1940.

Immediate cause of death: Cerebral Hemorrhage ?

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None.

Of autopsy: None.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 4/13/40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

03841

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131E)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 4 days.

Stay in this community (yrs., or mos., or days) 80 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 180 Wineow St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Richard A Neal.

3. (b) Social Security Number ~~None~~ 215-12-7976

4. Sex Male

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elvira Hurt.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1875

8. AGE: Years 64 | Months | Days | If less than one day hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business

FATHER 12. Name unknown

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Mrs Elvira Neal.

Address 180 Wineow St. Cumb'd Md

17. Removal. (Burial, cremation, or removal. Which?) Date thereof Apr. 22 '40 (month) (day) (year)

Cemetery or crematory

Location Bille, Va.

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

April 23 1940 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 20, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 16, 1940, to Apr. 20, 1940 and that I last saw him alive on Apr. 20, 1940.

Immediate cause of death	DURATION
Rheumatic Cardio-Vascular Disease	
Mitral Stenosis	1939
Due to Chronic Nephritis	1939
Due to Uraemia	1940
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Jurrett M. D. or other

Address Cumberland, Md Date signed Apr. 22, 1940.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

T I

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(50)

03842

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 226 Elder St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 226 Elder St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Grace Ellen Nealis

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 8 1899

8. AGE: Years 41 Months — Days 12 If less than one day hrs. min.

9. Birthplace Higginsville W. Va.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

FATHER
12. Name Joseph M Nealis
13. Birthplace Ill.

MOTHER
14. Maiden name Maggie J Haines
15. Birthplace W. Va.

16. Informant Joseph M Nealis.
Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 23 '40 (month) (day) (year)

Cemetery or crematory Ft Ashby Cem.

Location Ft Ashby W. Va.

18. Funeral director Louis Stein Inc
Address Cumberland

19. April 23 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 20 - 1940, at 12 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1940, to April 20 1940, and that I last saw her alive on April 20 1940.

Immediate cause of death Carcinoma of Breast — DURATION 6 M.?

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide NO Date of ✓

Where did injury occur? ✓ (City or town) ✓ (County) ✓ (State)

Injured at home, farm, industry, public place (where?) ✓

Means of injury Injured at work?

23. SIGNATURE Geo R Paulman M. D. or other

Address Cumb Md Date signed April 22 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(T)

RECEIVED
MAY 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03843

93-d

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Corriganville Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 60 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Corriganville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Anna J. Tickel

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Late Henry H. — 6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 29 - 1859

8. AGE: Years	Months	Days	If less than one day
80	4	13	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation ~~X~~ At Home

11. Industry or business

FATHER 12. Name Henry Deany

13. Birthplace Germany

MOTHER 14. Maiden name Lucinda Heiser

15. Birthplace Germany

16. Informant Mrs Anna Tickel

Address Brownsville, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 14-40 (month) (day) (year)

Cemetery or crematory Greenmount

Location Cumberland Md

18. Funeral director W. L. Lamparter

Address Cumberland, Md.

19. 4/14/40 (Date rec'd by registrar) 19 J. Lloyd Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1940, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1940, to April 12 1940

and that I last saw h 2R alive on Apr 11th 1940

Immediate cause of death	OURATION
Chronic Arteris Sclerosis	2 yrs.
Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John. A. Lapper M.D. M. D. or other

Address Hyndman. Pa Date signed 4/13/40

RECEIVED
MAY 11 1940
BUREAU U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134)

CERTIFICATE OF DEATH

03844

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 4 weeks

Stay in this community (yrs., or mos., or days) 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MD. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 2 BOONE ST. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME O'BRYON, CHARLES MR.

3. (b) Social Security Number None 213-12-9399

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife Mary McLelland O'Bryon

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 5, 1876

8. AGE: Years	Months	Days	If less than one day
63	11	21	____ hrs. ____ min.

9. Birthplace Connellsville, Pa. (Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal Mine

FATHER 12. Name Geo. O'Bryon

13. Birthplace Friendsville Md

MOTHER 14. Maiden name Louisa Kessler

15. Birthplace Friendsville Md.

16. Informant Johnna Wimer

Address 2 Boone St Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 28, 1940 (month) (day) (year)

Cemetery or crematory Chestnut Hill

Location Connellsville, Pa

18. Funeral director Jacob Zofer

Address Cumberland, Md

19. April 27, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. R. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 26, 1940 12:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/25/40 19__ to 4/26/40 19__, and that I last saw h alive on 4/26/40 19__

Immediate cause of death	DURATION
Chr. Myocarditis	2.
Chr. Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard J. Williams M.D. M. D. or other

Address 34 Va. Ave. Date signed 4/27/40

RECEIVED
MAY 7 1940
BUREAU V. S.

Has 24 on B.C.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-a)

CERTIFICATE OF DEATH

03845

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 mo 29 da

Stay in this community (yrs., or mos., or days) 1 mo 29 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town La Vale Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.D. Cumberland

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Ann Lee Paddleford

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23, 1940

8. AGE:

Years	Months	Days	If less than one day
	1	29	hrs. min.

9. Birthplace Cumberland Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name Justice Paddleford

13. Birthplace Washington D.C.

MOTHER — 14. Maiden name Gertrude Robinson

15. Birthplace Gaithersburg Md

16. Informant Mrs Gertrude Paddleford

Address La Vale Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Apr 23, 1940 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Washington D.C.

18. Funeral director Jacob Bafer

Address Cumberland

19. April 22 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 22 1940, at 1:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23, 1940, to Apr. 22, 1940, and that I last saw h m alive on Apr. 21, 1940.

Immediate cause of death Hydrocephalus

Due to Spina Bifida

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

DURATION
2/23/40
3/23/40

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. E. Moore, M.D. M. D. or other

Address Medical Bldg Date signed 4/22/40

VS A15 (1)

3470 Rx

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63-6

CERTIFICATE OF DEATH

03846

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MD (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town WESTERNPORT Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME

MRS. MARY PAGENHARDT

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife STEVEN PAGENHARDT

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) MARCH 8, 1880

8. AGE: Years	Months	Days	If less than one day
60	1	22	hrs. min.

9. Birthplace ILLINOIS (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name THOMAS MAC KINNON
13. Birthplace SCOTLAND

MOTHER
14. Maiden name MARION MACKEY
15. Birthplace MARYLAND

16. Informant STEVEN PAGENHARDT

Address WESTERNPORT, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2, 1940 (month) (day) (year)

Cemetery or crematory Philos Cemetery

Location Westernport, Md

18. Funeral director David S. Boal

Address Westernport, Md.

19. April 30, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1940 12:04 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1940, to April 29, 1940, and that I last saw h[illegible] alive on April 29, 1940.

Immediate cause of death Toxic — Adenomata of Gastric Extreme Dyspn[illegible] DURATION 1 week

Due to Sarcoma Adrenoma Activated by not known

Due to

Other conditions Essential Hypertension 2 Months

(Include pregnancy within 3 months of death)

Major findings Of operations Sarcoma Adrenomata about size of Blue Plum

Of autopsy No.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins M. D. or other 4-30-40

Address Cumbd Date signed

DRS. HAWKINS & WILLIAMS

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

03847

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 532 Valley St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 532 Valley St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Lillian L. Price

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B (b) Name of husband or wife: Christopher Price
6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb 13 1867

8. AGE:

Years	Months	Days	If less than one day
73	2	2	hrs. min.

9. Birthplace: Hancock Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Robert A. Kems
13. Birthplace: Md.
MOTHER 14. Maiden name: Unknown.
15. Birthplace:
16. Informant: Robert A. Price
Address: Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 17 '40 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland
18. Funeral director: Louis Stein Inc.
Address: Cumberland
19. April 16 1940 (Date rec'd by registrar) J. P. Hamilton, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 15. 1940, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 10 1940, to Apr 15 1940, and that I last saw h— alive on Apr 13 1940.

	DURATION
Immediate cause of death: Uraemic Coma	
Due to: Chronic Nephritis	2 yrs
Due to: Diabetes Mellitus	5 yrs
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos. A. Evans M. D. or other
Address: Cumberland, Md. Date signed Apr 18-40

RECEIVED
MAY 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

93848

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Vale Summit

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Vale Summit Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Robert A. Radcliff

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife May Radcliff

6(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Nov 26 - 1860

8. AGE: Years	Months	Days	If less than one day
79	4	22	hrs. min.

9. Birthplace Vale Summit - Alleg. Md.

(Town, county, and state)

10. Usual occupation retired merchant

11. Industry or business Grocery Store

FATHER 12. Name Jonathan Radcliff

13. Birthplace England

MOTHER 14. Maiden name

15. Birthplace

16. Informant Mrs May Radcliff

Address Vale Summit, Md

17. Burial Date thereof April 21-1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery ~~or crematory~~ Vale Summit

Location Vale Summit, Md.

18. Funeral director J. L. Durst

Address Frostburg, Md.

19. April 21 1940 Mrs. A. P. Walker

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18th 1940, at 12 20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1940, to April 17 1940, and that I last saw him alive on April 17 1940.

Immediate cause of death	DURATION
Cardio-Vascular Renal Disease	2 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Gatten M.D.

M. D. or other

Address Frostburg, Md Date signed 4/19/40

RECEIVED
MAY 4 1940
BUREAU V. S.

03849

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: McCool
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 58 Howard St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: McCool Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 58 Howard
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: X

3. (a) FULL NAME: Walter Edgar Ravenscroft.

3. (b) Social Security Number: 705-10-0381

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Ida B. Clark

6(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): May 20, 1875

8. AGE:

Years	Months	Days	If less than one day
64	10	14	hrs. min.

9. Birthplace: Bloomington, Md.
(Town, county, and state)

10. Usual occupation: Retired Car Repairman,

11. Industry or business: B.& O.R.R. Co.

FATHER
12. Name: George Ravenscroft,
13. Birthplace: Allegany Co., Md.

MOTHER
14. Maiden name: Margaret Biggs,
15. Birthplace: Kingwood, W.Va.

16. Informant: Mrs. W.E. Ravenscroft,
Address: McCool, Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 7, 1940 (month) (day) (year)

Cemetery or crematory: Philo Cemetery

Location: Westernport, Md.

18. Funeral director: B.W. Markwood.
Address: Keyser, W.Va.

19 April 6 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4, 1940 19 , at 4.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1932, to 4-4 1940, and that I last saw him alive on 4-4 1940.

Immediate cause of death: myocarditis acute decompensation

Due to: arteriosclerosis
Chronic myocarditis. [illegible]

Due to: Duration: six years.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: none Date of

Where did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): none

Means of injury: none Injured at work?

23. SIGNATURE: [signature] MD
M. D. or other

Address: Keyser W.Va. Date signed: 4-5-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

038509

Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Midlothian
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midlothian Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Harry H. Reitenbaugh
3. (b) Social Security Number: 213-03-5211

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Jane Reitenbaugh
6(c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): Dec 5 1878

8. AGE: Years 61 | Months 3 | Days 29 | If less than one day — hrs. — min.

9. Birthplace: Union Co Penn.
(Town, county, and state)
10. Usual occupation: Coal Miner
11. Industry or business: Coal Mines
FATHER
12. Name: Isaac Reitenbaugh
13. Birthplace: Pennsylvania
MOTHER
14. Maiden name: unknown
15. Birthplace: Unknown
16. Informant: Clyde Hassinger
Address: Midlothian, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 8-40 (month) (day) (year)
Cemetery or crematory: Allegany
Location: Frostburg, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. 4-8-40 (Date rec'd by registrar) 1940 Mrs. A. R. Hacker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1940, at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1940, to Apr 6 1940, and that I last saw him alive on April 4 1940.
Immediate cause of death: Carcinoma of Stomach — DURATION: ?
Due to: —
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)
Major findings: —
Of operations:
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D.
M. D. or other
Address: Frostburg Md. Date signed: Apr 6 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (73-B)

Reg. Dist. No. 2

CERTIFICATE OF DEATH

03851

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Flintstone (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) 78 yr. 10-20

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Flintstone (If outside city or town limits, write RURAL and give town)

(d) Street No. — (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Elias J. Roberts

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Agnes Roberts

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1861

8. AGE: Years 78 Months 10 Days 20 If less than one day ____ hr. ____ min.

9. Birthplace Allegany County, Maryland (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER

12. Name John Edward Roberts

13. Birthplace Allegany County, Maryland

MOTHER

14. Maiden Name Jane Dicken

15. Birthplace Bedford Co. Penn.

16 (a) Informant Mrs E. J. Roberts

(b) Address Flintstone, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 30 1940 (month) (day) (year)

171 (c) Cemetery or crematory Hill Crest

Location Cumberland, Md

18 (a) Funeral director Hafer

(b) Address Cumberland, Md

19 (a) Apr 27-40 (Date rec'd by registrar) (b) D. Bennett Registrar

MEDICAL CERTIFICATION

20. Date of death April 27 - 1940, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1940, to April 27 1940, and that I last saw him alive on April 26 1940.

Immediate cause of death Osteomyelitis

Due to Progressive Anemia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration: 16 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. P. Twigg M.D. M. D, or other

Address Flintstone Date signed 4-27-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 6 1911

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

CERTIFICATE OF DEATH

03852

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany.

City or town: Vale Summit.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insl. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 3 months.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany.

City or town: Vale Summit. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles Buddy Robertson.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Child.

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 20, 1940

8. AGE:

Years	Months	Days	If less than one day
	3	29	hrs. min.

9. Birthplace: Frostburg, Allegany, Md.

(Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER

12. Name: Melvin Robertson

13. Birthplace: Midland Md.

MOTHER

14. Maiden name: Irene Loar,

15. Birthplace: Loartown, Md.

16. Informant: Mrs Irene Loar

Address: Vale Summit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20, 1940 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Vale Summit.

18. Funeral director: Jacob Hafer

Address: Frostburg Md.

19. April 20 1940 (Date rec'd by registrar) Mrs. G. B. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19th., 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,

and that I last saw h alive on 19.

Immediate cause of death: Probably accidental suffocation. (died during the night, discovered by mother in morning, that death had occurred)

DURATION

Due to

Due to

Other conditions: had a severe cold cold the day before death, otherwise robust.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: April 19th 1940

Where did injury occur? Vale Summit, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: probably suffocation Injured at work?

23. SIGNATURE: Clarence H. Johnson M.D.

Address: Cumberland, Maryland. M. D. or other

Date signed: 4/19/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAY 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

03853

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 301 Harrison St
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 17 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 301 Harrison St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Hetrick Royce

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6 (b) Name of husband or wife Anna Elizabeth Whitacre Royce
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1861

8. AGE:

Years	Months	Days	If less than one day
78	7	13	hrs. min.

9. Birthplace Great Cacapon W Va (Town, county, and state)
10. Usual occupation Laborer - Retired
11. Industry or business B & O R R.
FATHER 12. Name Great Cacapon W. Va.
13. Birthplace Not Known
MOTHER 14. Maiden name Not Known
15. Birthplace Not Known
16. Informant Mrs. M. S. Duncan
Address 301 Harrison St Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 10, 1940 (month) (day) (year)
Cemetery or crematory Levels
Location Levels W. Va.
16. Funeral director Jacob Hafer
Address Cumberland, Maryland
19. April 9 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1940, at 3:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1940, to April 8 1940, and that I last saw h[illegible] alive on April 7 1940

Immediate cause of death	DURATION
Cyanosis Nephritis	1-1-59
Chronic Myocarditis	1-1-40
Due to Arteriosclerosis	1935
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE H. C. Eleanor M.D. M. D. or other
Address 126 N Mech St. Cumberland Date signed 4/9/40

Eleanor

RECEIVED
MAY 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W)

CERTIFICATE OF DEATH

03854

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: H01 md. Ave -

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 401 Maryland Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Charles Green Rumsey

3. (b) Social Security Number 220-10-1822

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	White	married

6 (b) Name of husband or wife Mary Elizabeth Rumsey

6(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Aug. 29 1869

8. AGE: Years	Months	Days	If less than one day
70	7	24	hrs. min.

9. Birthplace Wilmington - Delaware
(Town, county, and state)

10. Usual occupation Paper maker

11. Industry or business Paper Mill

FATHER 12. Name Charles G. Rumsey

13. Birthplace unknown

MOTHER 14. Maiden name Esther Downing

15. Birthplace Delaware

16. Informant Miss Madeline Rumsey (Daughter)

Address 4115 Wisconsin Ave N.W. Washington, D.C. apt. 103

17. Removal (Burial, cremation, or removal. Which?) Date thereof Apr. 25 1940 (month) (day) (year)

Cemetery or crematory Mt. Olivet -

Location Washington, D.C.

18. Funeral director W.N. Fredlack

Address Piedmont, W.Va.

19. Apr. 24 1940 (Date rec'd by registrar) A. Baynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1940, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940, to Apr. 23 1940, and that I last saw him alive on April 23 1940.

	DURATION
Immediate cause of death Gangreen Both Feet	3 month
Due to Diabetes	6 months
Due to	
Other conditions arteriosclerosis	4 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P E Berry M.D.
M. D. or other

Address Piedmont W.Va. Date signed 4/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
MAY 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

03855

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 640 Shriver Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 31 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 640 Shriver Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Carlton Russell

3. (b) Social Security Number 214-05-4791

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Katherine Burdett Russell

6(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1880

8. AGE: Years 59 Months 5 Days 16 If less than one day ____ hrs. ____ min.

9. Birthplace Sunderland, England (Town, county, and state)

10. Usual occupation Wash House

11. Industry or business Brewery

FATHER 12. Name Not Known

FATHER 13. Birthplace Not Known

MOTHER 14. Maiden name Not Known

MOTHER 15. Birthplace Not Known

16. Informant Mrs Mary Russell

Address 640 Shriver Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 6, 1940 (month) (day) (year)

Cemetery or crematory Hill Crest

Location Cumberland

18. Funeral director Jacob Zeger

Address Cumberland

19. April 6, 1940 (Date rec'd by registrar) J. L. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1940, at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 1940, to April 3 1940 and that I last saw h alive on April 3 1940.

Immediate cause of death Pulmonary Hemorrhage — DURATION 2 days

Due to So far as is known, death was due to metastatic carcinoma of the lung. Cause

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Johnson M. D. M. D. or other

Address Cumberland, Md Date signed 4-3-40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

4B-B

03856

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 700 Wills Creek Ave

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 700 Wills Creek Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Francis Sell.

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr 16 1879

8. AGE:

Years	Months	Days	If less than one day
60	11	24	hrs. min.

9. Birthplace Cumberland, Allegany Co., Md (Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business General.

FATHER

12. Name Lawrence Sell.

13. Birthplace Germany.

MOTHER

14. Maiden name Margaret Smith

15. Birthplace Germany

16. Informant Mrs E. M. Spence.

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 11 40 (month) (day) (year)

Cemetery or crematory Sts. Peter & Paul Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc.

Address Cumberland.

19. April 10, 1940 (Date rec'd by registrar) J. P. Franklin M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 8 - 1940, at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-7-1940 to 4-7-1940 and that I last saw him alive on 4-7-1940

Immediate cause of death	DURATION
Carcinoma of stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operation

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. ~~or other~~

Address Cumberland Date signed 4-9-40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

03857

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hosp.

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 18 North Centre St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Infant Shanholt

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6(c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.): April 24 - 40

8. AGE: Years | Months | Days: 1 | If less than one day ___ hrs. ___ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Harvey Shanholt
13. Birthplace: Md.

MOTHER
14. Maiden name: Alice Leasure
15. Birthplace: Maryland

16. Informant: Harvey Shanholt
Address: Cumberland Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof 4-27-40 (month) (day) (year)

Cemetery or ~~crematory~~: Rose Hill

Location: Cumberland, Md.

18. Funeral director: V. L. Lamperau
Address: Cumberland, Md.

19. 4/27 1940 (Date rec'd by registrar) Joseph P. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 25 1940, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 24 1940, to Apr 25 1940, and that I last saw him alive on Apr 19

Immediate cause of death: Premature Birth

Due to: 6 Mos.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos. A. Lowe M. D. or other

Address: Cumberland Md Date signed 4/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

03858

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 30 days

Stay in this community (yrs., or mos., or days) 61 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 407 Oldtown Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henry Alonza Shaw

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clarence Robinson Shaw

6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1878

8. AGE: Years 61 Months 7 Days 23 If less than one day hrs. min.

9. Birthplace Cumberland, Md.

(Town, county, and state)

10. Usual occupation Laborer - Retired

11. Industry or business B. & O. R. R.

FATHER

12. Name Isaac Shaw

13. Birthplace Unknown

MOTHER

14. Maiden name Mary Elizabeth Rice

15. Birthplace Cumberland Md

16. Informant Mrs Robert Platt

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 7, 1940 (month) (day) (year)

Cemetery or crematory Mt Hermon

Location Mt Road Cumberland Md

18. Funeral director Jacob Hofer

Address Cumberland, Md

19. April 10, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/40 19 , at 8:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on April 4 1940.

Immediate cause of death Dementia Praecox

DURATION

Due to

Due to

Other conditions Otitis Media

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE L. B. Mathews M.D. M. D. or other

Address 122 S. Centre Date signed 4/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (83-a)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

03859

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 146 Polk St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 67 Yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 Polk St (If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Mary Ida Shaw

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/17/1872

8. AGE: Years 67 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Cumberland (Town, county, and state)

10. Usual occupation Home duty

11. Industry or business Own Home

FATHER
12. Name Chas E. Shaw
13. Birthplace Cumberland

MOTHER
14. Maiden Name Mary Heaveney
15. Birthplace Cumberland

16 (a) Informant Miss Elsa Shaw
(b) Address 146 Polk St City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/40 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Cumberland

18 (a) Funeral director Wm H Kight
(b) Address Cumberland Md

19 (a) April 10, 1940 (Date rec'd by registrar) (b) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death April 7 1940, at 9 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 7 1940 to Apr 9 1940, and that I last saw him alive on Apr 8 1940.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. A. Trenaskis M.D. (M. D. or other)
Address Cumberland, Md Date signed Apr 9-40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03860

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 509 N. Mechanic st
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 509 N. Mechanic st
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Harriet Smith

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George Smith
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1857

8. AGE: Years	Months	Days	If less than one day
83	5	15	hrs. min.

9. Birthplace Pennsa (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Henry Krantz
13. Birthplace Pennsa
MOTHER 14. Maiden name Hester Bowerman
15. Birthplace Pennsa
16. Informant Miriam M. Shields
Address 509 N. Mechanic st.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Apr 15 1940 (month) (day) (year)
Cemetery or crematory Mt Pleasant Cemetery
Location Mt Pleasant Pennsa.
18. Funeral director V. L. Hempsenne.
Address Cumberland Md.
19. April 15 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1940, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1940 to April 11 1940
and that I last saw her alive on April 10 1940

Immediate cause of death	DURATION
Chronic Vascular	
Due to Heart Disease	about 1934
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M E Bowers M. D. or other
Address 133 Va ave Date signed 4/13/40

RECEIVED
MAY 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

(131-E)

CERTIFICATE OF DEATH

03861

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Frostburg, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 71 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Frostburg, Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Bowery St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Zipporah Sperry

3. (b) Social Security Number none

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Single.
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 26, 1858

8. AGE: Years 81 Months 10 Days 15 If less than one day hrs. min.

9. Birthplace Zehlman, Allegany, Md.
(Town, county, and state)
10. Usual occupation House work
11. Industry or business At Home
FATHER 12. Name Benjamin Sperry
13. Birthplace England
MOTHER 14. Maiden name Sarah Palmer
15. Birthplace England.
16. Informant Wm C. Morgan
Address 153, Bowery St Frostburg.
17. Burial Date thereof April 13, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Allegany
Location Frostburg, Md
18. Funeral director Jacob Hafer
Address Frostburg Md
19. April 13 1940 Mrs. A. R. Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1940, at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1940, to April 11 1940; and that I last saw her alive on April 11 1940.

Immediate cause of death
chronic myocarditis
chronic nephritis
Due to Senility
Mal-nutrition
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION
5 years.
3 years.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M.D.
M. D. or other
Address Frostburg, Md Date signed 4/13/40

Dr Diehl.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1960
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

Reg. Dist. No. 4 — 03862

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) Stillborn

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 402 South St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn Boy Stewart

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Infant

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

Stillborn

9. Birthplace Cumberland, Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John Stewart

13. Birthplace Cumberland

MOTHER 14. Maiden name Thelma Barker

15. Birthplace Ridgley W. Va.

16. Informant John Stewart

Address 402 South St

17. Cremation (Burial, cremation, or removal. Which?) Date thereof April 9, 1940 (month) (day) (year)

Cemetery or crematory Zafes Funeral Home

Location Cumberland Md

18. Funeral director Jacob Dopey

Address Cumberland

19. April 9, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

Barrow

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1940, at 3A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death STILL BORN — DURATION

Due to PREMATURITY

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE W B Barrow M.D.

M. D. or other

Address 122 Baltimore St — Date signed 4/9/40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

03863

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Rear Walnut St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 48 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 440 Columbia St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Joseph F. Stitcher

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Irma P. Johnson

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 11 1891

8. AGE:

Years	Months	Days	If less than one day
48	9	17	hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Butcher.

11. Industry or business: Own Business

FATHER

12. Name: John Stitcher

13. Birthplace: Germany.

MOTHER

14. Maiden name: Caroline Bucker

15. Birthplace: Md.

16. Informant: Mrs Irma Stitcher

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 26 40 (month) (day) (year)

Cemetery or crematory: St Peter + Paul's Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Apr 25, 40 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23rd about 19 40, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death: 25 Bullet gun shot wound of head - Killed instantly

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 4/23/1940

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) Riverslaughter

Means of injury: gun shot Injured at work? Yes

23. SIGNATURE: Thomas H. Bowers M.D. M. D. or other

Address: Cumberland, Md. Date signed 4/23/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAY 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

(94a)

03864

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

61 Grant St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany.

City or town Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 61 Grant St Frostburg

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Nellie McGregor Strube

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6 (b) Name of husband or wife Daniel Strube.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1874

8. AGE: Years 65 | Months 9 | Days 0 | If less than one day hrs. min.

9. Birthplace Scotland.

(Town, county, and state)

10. Usual occupation House work at Home.

11. Industry or business

FATHER 12. Name Robert McGregor

13. Birthplace Scotland

MOTHER 14. Maiden name Ellen McAlpin

15. Birthplace Scotland

16. Informant Mrs Tillie Bradley

Address 61 Grant St - Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 10 1940 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. 4-9-1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 7 1940, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 31 1940, to Apr 7 1940, and that I last saw her alive on Apr 6 1940

Immediate cause of death	DURATION
Coronary Thrombosis	7 day
Due to Chr Myocarditis	several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm Lane Jr MD M. D. or other

Address Frostburg Md Date signed Apr 8 1940

RECEIVED
MAY 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-E)

03865

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 350 Baltimore Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mr. Samuel Swartz

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Minnie Freeman
6(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): July 12, 1884

8. AGE:

Years	Months	Days	If less than one day
55	8	29	hrs. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business

FATHER
12. Name: Jacob Swartz
13. Birthplace: Russia

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs. Minnie F. Swartz
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 10 1940 (month) (day) (year)
Cemetery or crematory: East End Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. April 10 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-19-1939, to 4-10-1940 and that I last saw him alive on 4-9-1940

Immediate cause of death: Carcinomatosis.

DURATION: ?

Due to: Carcinoma of prostate

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm F. Williams M. D. or other
Address: Cumberland Date signed: Md.

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-m)

CERTIFICATE OF DEATH

03866

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hosp.
Stay in hospital or inst. (yrs., or mos., or days): 1 Day
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Route #2, Baltimore Pike
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Boy Teter

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 1, 1940

8. AGE: Years | Months | Days | If less than one day: hrs. 5 min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Jacob Teter
13. Birthplace: Petersburg, W. Va

MOTHER
14. Maiden name: Mabel Stonestreet
15. Birthplace: Petersburg, W. Va.

16. Informant: Jacob Teter.
Address: Cumberland, Md. Route #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1, 1940 (month) (day) (year)

Cemetery or crematory: Green Mount Cem.
Location: Murley's Branch, Md.

18. Funeral director: Jacob Teter - Father
Address: Route #2, Cumberland, Md

19. April 1, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1, 1940, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1940, to April 1 1940, and that I last saw him alive on April 1 1940.

	DURATION
Immediate cause of death	
Due to Malformation	
Due to There were no bones covering the brain. C.S.R.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. P. Twigg, M.D.
M. D. or other
Address: Flintstone Date signed:

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

CERTIFICATE OF DEATH

03867

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 405 Pulaski St.
Stay in hospital or insl. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 77 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 405 Pulaski St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Elizabeth Catherine Leibrant Thompson
3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife: William E. Thompson
6(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Jan 16, 1863

8. AGE: Years	Months	Days	If less than one day
77	3	3	hrs. min.

9. Birthplace: Cumberland, Md (Town, county, and state)
10. Usual occupation: House work
11. Industry or business: Own home
FATHER 12. Name: George E. Leibrant
13. Birthplace: Germany
MOTHER 14. Maiden name: Elizabeth Reith
15. Birthplace: Germany
16. Informant: George A Thompson
Address: 405 Pulaski St. City
17. Burial (Burial, cremation, or removal. Which?) Date thereof apr 22 1940 (month) (day) (year)
Cemetery or crematory: Hill Crest Cemetery
Location: Cumberland, Md
18. Funeral director: Jacob Hafer
Address: Cumberland Md
19. April 22, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1940, at 1:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 1938, to apr 19 1940, and that I last saw h alive on apr 18 1940.

Immediate cause of death	DURATION
Uremia Coma	2 days
Due to Chronic Nephritis	10 yrs
Due to Organic Heart Disease	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos. H. Thompson M. D. or other
Address: Cumberland Md Date signed apr 20, 40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

03868

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 824 N. Mechanic Street
Stay in hospital or inst. (yrs., or mos., or days): 40 yrs.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 824 N. Mechanic St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Christina B. Thuss

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: August Thuss
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1, 1859

8. AGE: Years	Months	Days	If less than one day
80	11	9	hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: John Phillips
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: William T. Thuss
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12, 1940 (month) (day) (year)
Cemetery or crematory: St. Luke Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. April 12, 1940 (Date rec'd by registrar) J. P. Kamblin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 1940, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24, 1940, to April 10, 1940, and that I last saw her alive on April 2, 1940

Immediate cause of death	DURATION
Cerebral hemorrhage	3 mo
Due to Arterial hypertension	Indef.
Due to Myocarditis	Indef.
Due to Chronic interstitial nephritis	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. M. Lee, M. D.
M. D. or other
Address: Cumberland, Md. Date signed: 4-10-40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

03869

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 103 S Center St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Md Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 103 S Center St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ella Virginia Troxell

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Geo Will Troxell

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15 1861

8. AGE: Years	Months	Days	If less than one day
78	4	10	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Crothers

13. Birthplace Md

MOTHER 14. Maiden name Sarah McKenzie

15. Birthplace Md

16. Informant Mr G W Troxell

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30, 40 (month) (day) (year)

Cemetery or crematory St Patrick's

Location Cumberland Md.

18. Funeral director Louis Stein Sons

Address Cumberland Md.

19. April 29, 1940 (Date rec'd by registrar) J. P. Franklin M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25-40 19 , at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16, 1938, to April 25, 1940, and that I last saw he alive on April 25, 1940

Immediate cause of death Apoplexy — DURATION: One week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C E Troxell M. D. or other

Address 105 S. Centre St. Date signed 4/26/40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-D)

CERTIFICATE OF DEATH

CD 03870

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County: Allegheny

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegeany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 8 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Ohio County:

City or town: Cleveland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Not known (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Truman Warnick

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: May Warnick

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 30, 1870

8. AGE:

Years	Months	Days	If less than one day
70	-	19	hrs. min.

9. Birthplace: Garrett Co., Md. (Town, county, and state)

10. Usual occupation: Conductor

11. Industry or business: Cleveland R.R.

FATHER 12. Name: Henry Warnick

13. Birthplace: Garrett Co., Md

MOTHER 14. Maiden name: Malala Junkins

15. Birthplace: Garrett Co., Md.

16. Informant: Mrs Jefferys

Address: 213 Charles St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 20, 1940 (month) (day) (year)

Cemetery or crematory: Oakland

Location: Oakland, Md.

18. Funeral director: Herbert C. Leighton

Address: Oakland, Md.

19. April 20, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18, 1940, 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1, 1940 to Apr 18, 1940 and that I last saw him alive on Apr 18, 1940

Immediate cause of death	DURATION
Chronic Myocarditis	1 year
Due to	
Due to	
Other conditions: Arteriosclerosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. F. Trevaskis M.D. M. D. or other

Address: Cumberland, Md Date signed: 4/18/40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-B)

03871

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 721 Oldtown Road

Stay in hospital or inst. (yrs., or mos., or days) 2 years

Stay in this community (yrs., or mos., or days) 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 721 Oldtown Road (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Scott Winfield Weaversling

3. (b) Social Security Number none

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sarah Mellott Weaversling

6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1861

8. AGE: Years 78 Months 7 Days 6 If less than one day ___ hrs. ___ min.

9. Birthplace Everett Pa (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own Farm

FATHER 12. Name Joseph Weaversling

13. Birthplace Everett Pa.

MOTHER 14. Maiden name Elizabeth Mellon

15. Birthplace Everett Pa

16. Informant Mrs Sarah Weaversling

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 23, 1940 (month) (day) (year)

Cemetery or crematory Mt. Union

Location Everett Pa

18. Funeral director Jacob Hafer

Address Cumberland Md.

19. April 23 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1940, at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1939, to April 21 1940, and that I last saw h[illegible] alive on April 20 1940.

Immediate cause of death Carcinomatosis — DURATION 6 mos

Due to Carcinoma of Prostate — 1-1-39

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ___ Date of ___

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury no Injured at work? no

23. SIGNATURE H W Chason MD M. D. or other

Address 126 Union St. Cumberland Md Date signed 4/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr Chason

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

03872

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(48-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 17 South Lee St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 17 South Lee St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Mrs Claudia V. Wentling

3. (b) Social Security Number None

4. Sex: F.

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm F. Wentling

6(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.): Apr 25 - 1894

8. AGE: Years 46 Months 0 Days 1 If less than one day ___ hrs. ___ min.

9. Birthplace: West Va (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER 12. Name: Wm McCormick

13. Birthplace: West Va

MOTHER 14. Maiden name: Margaret Engle

15. Birthplace: West Va

16. Informant: Wm Wentling

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 29-40 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland Md.

18. Funeral director: V. L. Temperene

Address: 202 Green St - Cumberland Md

19. April 29, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1940, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1939, to April 26 1940, and that I last saw h[illegible] alive on [illegible] 1940.

Immediate cause of death: Hemorrhage of Bladder & Uterus

Due to: Carcinoma of Cervix and Vladder

Due to: Primary carcinoma of uterine cervix.

Other conditions: Duration: one year. W.G.R.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 2 days

Repeat

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F. Alan G. Murray M.D. M. D. or other

Address: 41 Green St Cumberland Date signed: April 27 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 7 1940
BUREAU V. S.

1940
46
1894

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

03873

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 118 Seymour St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: WHETZEL, BABY GIRL

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 8, 1940

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 45 min.

9. Birthplace: Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Howard Whetzel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Robinette, Clara
15. Birthplace: Maryland

16. Informant: Howard Whetzel
Address: 118 Seymour St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 9 40 (month) (day) (year)
Cemetery or crematory: Aber. Cem
Location: Mineral Co. W. Va.

18. Funeral director: Tomlinstein Bros
Address: Cumberland

19. April 9 (Date rec'd by registrar) 19 40 J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 40 19 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4/8/40 19 to 4/8/40 19, and that I last saw h e alive on 4/8/40 19

Immediate cause of death	DURATION
Pre-maturity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Richard Williams M.D.
M. D. or other
Address: 37 Va. Ave. Date signed 4/9/40

RECEIVED
MAY 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS,

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03874

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days) 4 Hrs.
Stay in this community (yrs., or mos., or days) 24 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 26 Browning St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frank Texas Wise

3. (b) Social Security Number None 205-05-8538

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14, 1916

8. AGE: Years	Months	Days	If less than one day
24	2	14	hrs. min.

9. Birthplace Cumberland, Maryland (Town, county, and state)
10. Usual occupation B&O Car repairer (Furloughed)
11. Industry or business Railroad
FATHER 12. Name William E. Wise
13. Birthplace Mifflinburg, Penna
MOTHER 14. Maiden name Bertha Edwards
15. Birthplace Midland, Maryland
16. Informant William E. Wise
Address 26 Browning St. Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1940 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.
18. Funeral director Jacob Hafer
Address Cumberland, Md.
19 April 30, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1940, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Gun-shot wounds of chest (12 gauge gun) — DURATION 4 hrs.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 4-28-40
Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Gun-shot Injured at work? No

23. SIGNATURE Phillip H. Boyon, M.D. M. D. or other
Address Cumberland, Md. Date signed 4-28-40

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAY 7 1940
BUREAU V. S.